MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town High Point
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town High Point
(If outside city or town limits, write RURAL and give nearest town)
Street No. Riverside Drive & Edgewood
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thomas William Althoff

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife Hazel M. Althoff
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March April 15 1907

8. AGE: Years	Months	Days	If less than one day
43			..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Chauffeur
11. Industry or business Bills Transit

FATHER
12. Name Michael Althoff
13. Birthplace Maryland

MOTHER
14. Maiden name Mary Hughes
15. Birthplace Ireland

16. Informant Hazel M. Althoff
Address Riverside Drive, High Point, Md.

17. Burial Date thereof Oct 31, 1950
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18. Funeral director Austin E. Donovan
Address 3818 Roland Ave, Balto Md.

19. 10/30/50 A. W. Merrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 1950 at 3.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1950 to Oct. 28 1950 and that I last saw him alive on October 21 1950

Immediate cause of death	DURATION
Carcinomatosis	4 months
Due to Carcinoma of throat	4 months
Due to 148X	
Other conditions None	
45 f	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Randall M. McLaughlin M.D.
M. D. or other
Address Pasadena R.D., Md. Date signed Oct 28 1950

VS A15 9-45 (5M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09879

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fort George G Meade
LENGTH OF STAY (in this place): 8 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U. S. ARMY HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Delaware — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Wilmington
STREET ADDRESS (If rural, give location): 1010 Read St

3. NAME OF DECEASED (Type or Print): (First) THOMAS (Middle) JOSEPH (Last) ANGELINE
4. DATE OF DEATH: (Month) October (Day) 24 (Year) 1950

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 22 June 1928
9. AGE last birthday: 22 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier
10b. KIND OF BUSINESS OR INDUSTRY: US Army
11. BIRTHPLACE (State or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If year, give war or dates of service): 8 days
16. SOCIAL SECURITY No.: –
17. INFORMANT AND ADDRESS: Service Records US Army Ft Geo G Meade, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Gun shot wound, perforating, point of entrance between 8th & 9th transverse process, back, left.

984.5 Antecedent cause(s) (b) Point of exit, 3d interspace, anterior chest, right, with destruction of great vessels.

166 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH: sudden

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes [X] No [ ]

21. ~~SUICIDE~~ HOMICIDE (Specify): Homicide
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Street
(CITY OR TOWN): Fort Geo G Meade (COUNTY): Anne Arundel (STATE): Md
TIME OF INJURY (Month) Oct (Day) 24 (Year) 50 (Hour) 1000
INJURY OCCURRED While at Work [X] Not While At work [ ]
HOW DID INJURY OCCUR? Shot by sentry

22. I hereby certify that I attended the deceased from ....., 19...., to ....., 19...., that I last saw the deceased alive on ....., 19...., and that death occurred at 1000 hrs m., from the causes and on the date stated above.

SIGNATURE: W. E. McGrath (Degree or title) ADDRESS: W. E. McGRATH, Captain, M.C. U. S. ARMY HOSPITAL, Ft Geo G Meade, Md. DATE SIGNED: 25 Oct 50

23. BURIAL, CREMATION REMOVAL (Specify): Removal
DATE: 25 Oct 50
NAME OF CEMETERY OR CREMATORY: Cathedral
LOCATION (City, town, or county): Wilmington (State): Del.

DATE REC'D BY LOCAL REG.: Oct 27, 1950
REGISTRAR'S SIGNATURE: E. K. Burnside E. K. BURNSIDE, CAPT., MSC
24. FUNERAL DIRECTOR: Lily & Zeiler, Inc, Baltimore, Maryland ADDRESS

60896

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 1950

MARYLAND STATE DEPARTMENT OF HEALTH

09880

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place) 50 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 25 East

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 25 East

3. NAME OF DECEASED (Type or Print) (First) HARRY (Middle) CLARENCE (Last) AYERS JR
4. DATE OF DEATH (Month) OCT. (Day) 7 (Year) 1950
5. SEX MALE
6. COLOR OR RACE WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) SINGLE
8. DATE OF BIRTH July 9 1899
9. AGE last birthday 50 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED NAVY CHIEF
10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME Harry Clarence Ayers, SR.
14. MOTHER'S MAIDEN NAME Mary E. Mitchell
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service U.S. Navy World War II
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Mildred Dodson (SISTER)

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
420.1	Immediate cause	(a) Coronary occlusion	sudden
94a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	unknown
		(c) Acute Myocarditis	5 years ago

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 10/7/50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF 10-11-50 NAME OF CEMETERY OR CREMATORY National LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Oct. 9, 1950 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

60896

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
OCT 10 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

09881

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BLVD. PARK PASADENA; LENGTH OF STAY (in this place) 36 YEARS; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ANNE ARUNDEL; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PASADENA. (RURAL); STREET ADDRESS (If rural, give location) BOULEVARD PARK.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JOSEPHINE	—	BAILEY	Oct	10	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
FEMALE	WHITE	WIDOW	JAN. 30, 1867	83 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWORK	OWN HOME	BALTIMORE MD	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
ELI SKIPPER	SADIE — UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
NO	NONE	VINCENT BAILEY BOULEVARD PK PASADENA. MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
491X Immediate cause (a)	Broncho Pneumonia	36 hrs
107 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)		
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Arthritis	Years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Oct 1, 1948, to Oct 10, 1950 that I last saw the deceased alive on Oct 10, 1950, and that death occurred at 9 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C. Amendelis	MD	651 N. Bentalou St	10/10/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	OCT-14-1950	MT. CARMEL	MOUNTAIN ROAD, A. A. Co. MD.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/14/50		Thomas W. Singleton	Glen Burnie Md.

RECEIVED
OCT 16 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09882

CERTIFICATE OF DEATH

Reg. Dist. No. 28 / 91

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville; LENGTH OF STAY (in this place): 8 mos. 24 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Howard; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ellicott City; STREET ADDRESS (If rural, give location): New Cut Road

3. NAME OF DECEASED (Type or Print): (First) William (Middle) (Last) Baldwin

4. DATE OF DEATH: (Month) (Day) (Year): 10/24/50 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): sincle

8. DATE OF BIRTH: about 1881 not known

9. AGE last birthday: 69 yrs.

If under 1 year: Months / Days

If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Howard County, Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Joseph Baldwin

14. MOTHER'S MAIDEN NAME: Arrie Butler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Generalized Arteriosclerosis	known since 1/30/50
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

450.0
97

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Senile Psychosis — known since 1/30/50

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): none m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 1/30/50, 19..., to 10/24/50, 19..., that I last saw the deceased alive on 10/24/50, 19..., and that death occurred at 2:15 P. m., from the causes and on the date stated above.

SIGNATURE: [signature] (Degree or title) ADDRESS: Crownsville, Md. DATE SIGNED: 10/24/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 10/28/50.

NAME OF CEMETERY OR CREMATORY: Odd Fellows Cemetery

LOCATION (City, town, or county) (State): Elkridge, Maryland.

DATE REC'D BY LOCAL REG.: 10-28-50

REGISTRAR'S SIGNATURE: [signature] K. M. Joyce

24. FUNERAL DIRECTOR ADDRESS: Easton Sons, Ellicott City, Md.

5589

RECEIVED
NOV 11 1950

09883

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GLEN BURNIE; MARYLAND; LENGTH OF STAY (in this place) 5 YEARS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 305 FIFTH, AVE., S.E.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ANNE ARUNDEL; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GLEN BURNIE.
STREET ADDRESS (If rural give location) 305 FIFTH, AVE., S.E.

3. NAME OF DECEASED (Type or Print): (First) SPENCER (Middle) D. (Last) BOBLITZ

4. DATE OF DEATH: (Month) OCT. (Day) 7 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: FEB. 6. 1885

9. AGE last birthday: 65 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): JOB SALESMAN

10b. KIND OF BUSINESS OR INDUSTRY: DRY GOODS.

11. BIRTHPLACE (State or foreign country): BALTIMORE, MD

12. CITIZEN OF WHAT COUNTRY? U. S

13. FATHER'S NAME: WILLIAM H. BOBLITZ.

14. MOTHER'S MAIDEN NAME: SARAH HALL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 216-01-6918

17. INFORMANT: MRS SPENCER D. BOBLITZ, 305 FIFTH, AVE. S.E., GLEN BURNIE, MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 **Immediate cause** (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

94a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary Sclerosis — unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M Claffey M.D. Deputy Medical Examiner Annapolis Md 10/7/50

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE THEREOF: OCT. 10 1950 — NAME OF CEMETERY OR CREMATORY: BALDWINS MEMORIAL — LOCATION (City, town, or county) (State): SEVERN CROSS ROADS, MILLERSVILLE MD

DATE REC'D BY LOCAL REG. 10/9/50 — REGISTRAR'S SIGNATURE L. D. Allen

24. FUNERAL DIRECTOR: Thomas W. Singleton — ADDRESS: Glen Burnie md.

27863

RECEIVED
OCT 10 1950
BUREAU U. S

MARYLAND STATE DEPARTMENT OF HEALTH

09884

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN West Annapolis
STREET ADDRESS (If rural, give location) 716 Giddings Avenue

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Elizabeth	B.	Boone	Oct	28	1950

5. SEX	6. COLOR OR RACE	7. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White		Oct. 16, 1869	81 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life. Can if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Housewife	Own Home	Maryland	U.S.A.

13. FATHER'S NAME Isaac Cox

14. MOTHER'S MAIDEN NAME Elvira Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No			Elvira B. Fagan

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Aneurysm of Abdominal Aorta	10 yrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) probably dissecting	24 hrs.
	(c)	

451X
30d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 10/27, 1950, to 10/28, 1950, that I last saw the deceased alive on 10/28/, 1950, and that death occurred at 4:40P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank M. Shipley	M.D.	63 College Ave. Annapolis	10/30/50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	Oct. 31, 1950	Cedar Blu H	Annapolis, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 31, 1950		John M. Taylor & Son	Annapolis, Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
NOV 1 1950
BUREAU V. S

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09885

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH · COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis — LENGTH OF STAY (in this place): 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland — COUNTY: A A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Davidsonville
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Rachel (Middle) (Last) Brown
4. DATE OF DEATH: (Month) Oct (Day) 4 (Year) 1950
5. SEX: Female
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 11/19/08
9. AGE last birthday: 41 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Davidsonville, Md
12. CITIZEN OF WHAT COUNTRY?:
13. FATHER'S NAME: Thomas Henry Brown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Annie Brown, Davidsonville, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

170x Immediate cause (a) Generalized Carcinomatosis — 3 mn.

Antecedent cause(s)

50 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma rt. breast

(c) Metastatic Carcinoma to lungs + Heart.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/2/50, 19....., to 10/4/50, 19....., that I last saw the deceased alive on 10/4/50, 19....., and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE: Albert L. Anderson MD (Degree or title) — ADDRESS: Annapolis Md — DATE SIGNED: 10/4/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 10/81/50 — NAME OF CEMETERY OR CREMATORY: Davidsonville — LOCATION (City, town, or county) (State): Davidsonville, Md.

DATE REC'D BY LOCAL REG.: Oct. 7, 1950 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR: T. A. Hardesty & Son — ADDRESS: Galesville, Md.

RECEIVED
OCT 10 1950
BUREAU V. S

09886

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH COUNTY A.A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 4 months 15 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED STATE Montgomery COUNTY Md
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sandy Spring Md
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Albert (Middle) Francis (Last) Carter
4. DATE OF DEATH (Month) 10 (Day) 7 (Year) 1950

5. SEX M.
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
8. DATE OF BIRTH about 2 4874
9. AGE last birthday 76 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME unknown
14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0 Immediate cause (a) Generalized arteriosclerosis

97 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: known; final admission May 23rd 1950

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....m., from the causes and on the date stated above.

SIGNATURE Jacob Marquester M.D. (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct 11 1950
NAME OF CEMETERY OR CREMATORY Sandy Spring
LOCATION (City, town, or county) Montgomery Co (State)

DATE REC'D BY LOCAL REG. Oct 8
REGISTRAR'S SIGNATURE Katherine M. Joyce
24. FUNERAL DIRECTOR Robert L. Snowden
ADDRESS Rockville Md

XVX99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

09887

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 33 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): Not known

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) M. (Last) Chesley
4. DATE OF DEATH: (Month) 10/29/50 (Day) (Year) 19

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single
8. DATE OF BIRTH: ~~about 1887~~ ~~not known~~
9. AGE last birthday: 63 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): not known
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: not known
14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
331x	Immediate cause	(a) Cerebral Hemorrhage	known for 1 day
830	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cerebral Arteriosclerosis	known for five years
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia, Hebephrenic Type — known since 11/30/17

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify): none
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE): none
TIME OF INJURY (Month) (Day) (Year) (Hour): none m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 10/13/41, 19....., to 10/29/50, 19....., that I last saw the deceased alive on 10/29/50, 19....., and that death occurred at 1:10 P. m., from the causes and on the date stated above.

SIGNATURE: Jacob Morgenstern M.D. (Degree or title) — ADDRESS: Crownsville, Md. — DATE SIGNED: 10/30/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 10/2/50
NAME OF CEMETERY OR CREMATORY: Mt. Auburn
LOCATION (City, town, or county) (State): Balto. Maryland

DATE REC'D BY LOCAL REG.: 10/31/50
REGISTRAR'S SIGNATURE: G. W. Hedrick JJ
24. FUNERAL DIRECTOR: Holland Funeral Home — ADDRESS: 1631 Druid Hill Ave.

XXX99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

09888

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Annapolis AA — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (in this place) 78 yr's.
HOSPITAL OR INSTITUTION OR STREET ADDRESS AA General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Annapolis COUNTY AA Md.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location) Franklin St. Annapolis, Md.

3. NAME OF DECEASED (Type or Print) (First) Sarah (Middle) (Last) Colbert

4. DATE OF DEATH (Month) 10 (Day) 21 (Year) 1950

5. SEX F

6. COLOR OR RACE Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) S

8. DATE OF BIRTH 1-11872

9. AGE last birthday 78 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Lower Marlboro Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Frank Colbert

14. MOTHER'S MAIDEN NAME Miriah Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Beatrice McKinnis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Uremia — 3 wks

592x
131b

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Glomerular Nephritis

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/7/, 1950, to 10/21/, 1950, that I last saw the deceased alive on 10/21/, 1950, and that death occurred at 2:55 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Frank M. Shipley M.D. 63 College Ave. Annapolis 10/23/50

23. BURIAL, CREMATION REMOVAL (Specify) B — DATE THEREOF 10-25-50 — NAME OF CEMETERY OR CREMATORY Brewer Hill — LOCATION (City, town, or county) Annapolis, AA (State) Md.

DATE REC'D BY LOCAL REG. Oct. 25, 1950 — REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR William Reese, 108 Washington St. Annapolis, Md. — ADDRESS

XV X99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 28
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

09889

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum | LENGTH OF STAY (in this place) 4 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 113 Archwood Ave

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Same COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Edward (Last) Dannettel

4. DATE OF DEATH: (Month) Oct. (Day) 7 (Year) 19-50

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: May 7 - 1862

9. AGE last birthday: 88 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter.

10b. KIND OF BUSINESS OR INDUSTRY: Houses

11. BIRTHPLACE (State or foreign country): Lancaster Pa.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: N.

17. INFORMANT: Mrs. Lenora Willridge d.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X **Immediate cause** (a) Cerebral Haemorrhage — Interval Between Onset and Death: 2 week.

83a **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis — 10 yr.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19-40, to 10/7/50, 19....., that I last saw the deceased alive on 10/7/50, 19....., and that death occurred at 10 A. m., from the causes and on the date stated above.

SIGNATURE: Chas. L. Ball Jr (Degree or title) | ADDRESS: Linthicum | DATE SIGNED: 10/7/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: 10/10/50 | NAME OF CEMETERY OR CREMATORY: London Park | LOCATION (City, town, or county) (State): Balto. Md.

DATE REC'D BY LOCAL REG. 10/9/50 | REGISTRAR'S SIGNATURE: H.W. Hedrick | 24. FUNERAL DIRECTOR: Wm Cook Inc. | ADDRESS: 1217 St. Paul St.

Don L.

30809

09890

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN South River
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. Co. Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN South River
STREET ADDRESS (If rural, give location) Edgewater P.O., Md

3. NAME OF DECEASED (Type or Print) (First) HARRY (Middle) W. (Last) DAVIS
4. DATE OF DEATH (Month) 10 (Day) 31 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, ~~(Specify)~~
8. DATE OF BIRTH 2/26/1868
9. AGE last birthday 82 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER
10b. KIND OF BUSINESS OR INDUSTRY Farm owner ~~Lobster~~
11. BIRTHPLACE (State or foreign country) A. A. Co.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS County Home Superintendent.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — 5 min.

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

94a (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Prostatic hypertrophy - Benign or Malignant ?

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1940, to 10/31, 1950, that I last saw the deceased alive on 10/27, 1950, and that death occurred at 3:30 P. m., from the causes and on the date stated above.

SIGNATURE Maurice Klawans, MD (Degree or title) ADDRESS Annapolis, Md DATE SIGNED 11/1/50

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) DATE THEREOF 11-3-50 NAME OF CEMETERY OR CREMATORY Private LOCATION (City, town, or county) (State) Riva, A.A. Co. Md.

DATE REC'D BY LOCAL REG. Nov. 2, 1950 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
NOV 6 1950
BUREAU V. S

09891

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Drury — LENGTH OF STAY (in this place): 30 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Drury
HOSPITAL OR INSTITUTION OR STREET ADDRESS:	STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Thomas (Middle) Daniel (Last) Davis

4. DATE OF DEATH: (Month) Oct (Day) 1 (Year) 1950

5. SEX: male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: March 6, 1877

9. AGE last birthday: 73 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Loborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Lothian, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Charles Davis

14. MOTHER'S MAIDEN NAME: Sara Jane Creek

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Jane E. Davis

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
450.0	Immediate cause	(a) Generalized Arteriosclerosis	15 yrs.
97	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cachexia	6 wks
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug, 1947, to 1 Oct, 1950, that I last saw the deceased alive on 13 Oct, 1950, and that death occurred at 12 30 P m., from the causes and on the date stated above.

SIGNATURE: R B Cassar — (Degree or title): MD — ADDRESS: Upper Marlboro, Md — DATE SIGNED: 1 Oct 50.

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Oct. 5, 1950 — NAME OF CEMETERY OR CREMATORY: Moses — LOCATION (City, town, or county): Drury (State): Md.

DATE REC'D BY LOCAL REG.: 10/3/50 — REGISTRAR'S SIGNATURE: W. A. Clayton

24. FUNERAL DIRECTOR: T. A. Hardesty & Son — ADDRESS: Galesville, Md.

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Husband, John W. Shertzer - Lothian, Md.

Surv. Children, John R. Shertzer - Wash. D.C.

Mr Wm. M. Shertzer - Tracys, Md.

Mrs Eva E. Watt - Owings, Md.

" Pearl L. Crandell - Lothian, Md

" Janie M. Mayo - Upperco, Md.

" Myra Moreland - Lothian, Md.

" Margaret B. Sears - Wash. D.C.

Mr Tilson M. Shertzer - Wash. D.C.

" Eldridge Shertzer - Wash. D.C.

" T. Leroy Shertzer - Wash. D.C.

2 P.M.
Thursday
home
P.M.

RECEIVED
OCT 5 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

09892

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Naval Academy Green house

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural, give location) Naval Academy Green house

3. NAME OF DECEASED (Type or Print): (First) Bessie (Middle) (n) (Last) Degen

4. DATE OF DEATH: (Month) Oct (Day) 28 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: 4/13/1884

9. AGE last birthday: 66 yrs. If under 1 year: Months; If under 24 hrs.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Rudolph Degen

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval Between Onset and Death: Sudden

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d (b) Myocardial Ins. & Myocardial Insufficiency — 4 years

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis — Several years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 25, 1950, to Oct 28, 1950, that I last saw the deceased alive on Oct 25, 1950, and that death occurred at 7 P.M., from the causes and on the date stated above.

SIGNATURE George C Bond (Degree or title) MD ADDRESS Annapolis Md DATE SIGNED 10-30-50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) | DATE THEREOF Oct 31, 1950 | NAME OF CEMETERY OR CREMATORY Cedar Bluff | LOCATION (City, town, or county) Annapolis, Md. (State)

DATE REC'D BY LOCAL REG. Oct 31, 1950 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR John M. Taylor & Son | ADDRESS Annapolis, Md.

RECEIVED
NOV 1 1950
BUREAU V. S

ITEMS 14, 17: AFF. FILMED 11-15-50 G128 LL (informant's affidavit)

09893

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 204 Hilltop Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Same COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Luther (Middle) Clinton (Last) Downs
4. DATE OF DEATH (Month) Oct. (Day) 29 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH April 2, 1874
9. AGE last birthday 76 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farme Impleton
10b. KIND OF BUSINESS OR INDUSTRY Seed Co.
11. BIRTHPLACE (State or foreign country) Ferndale Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Wm Downs
14. MOTHER'S MAIDEN NAME Elizabeth [illegible] WELHAM
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 212-01-6153
17. INFORMANT Wife - FLORENCE L. DOWNS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardio-Vascular Disease	6 mo.
422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio Sclerosis	5 yr.
93d	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb., 1950, to Oct. 29, 1950, that I last saw the deceased alive on Oct. 29, 1950, and that death occurred at 4 P. m., from the causes and on the date stated above.

SIGNATURE Chas. L. Ball Jr. (Degree or title) ADDRESS Linthicum DATE SIGNED 10/29/50 Md.

23. BURIAL, CREMATION REMOVAL (Specify) burial
DATE THEREOF 10/31/50
NAME OF CEMETERY OR CREMATORY Cedar Hill
LOCATION (City, town, or county) (State) Anne Arundel Co., Md.
DATE REC'D BY LOCAL REG. 10/30/50
REGISTRAR'S SIGNATURE A. W. Hedrick
24. FUNERAL DIRECTOR John O. Mitchell & Sons, Inc.-1900 Eutaw Pl. ADDRESS John O. Mitchell Jr.

JT ✓ 31860

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

09894

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Anne Arundel Cty MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 4 m. 14 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS State Hospital Crownsville

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A. Co
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville Md
STREET ADDRESS (If rural, give location) Crownsville Md

3. NAME OF DECEASED (Type or Print) (First) Nathaniel (Middle) (Last) Dunlap
4. DATE OF DEATH (Month) 10 (Day) 21 (Year) 1950

5. SEX M
6. COLOR OR RACE Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single
8. DATE OF BIRTH July 4, 1942
9. AGE last birthday 8 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Baltimore City
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Nathaniel Dunlap
14. MOTHER'S MAIDEN NAME Irene Schley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT AND ADDRESS Hospital record

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General exhaustion — INTERVAL BETWEEN ONSET AND DEATH: one week

325.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Spastic Idiot

84a

(c) Known once a month

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 7, 1950, to Oct. 21, 1950, that I last saw the deceased alive on Oct. 21, 1950, and that death occurred at 12.25 p. m., from the causes and on the date stated above.

SIGNATURE Jacob Moncuster M.D. (Degree or title) ADDRESS Crownsville Md State Hospital DATE SIGNED 10-21-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 10-25-50
NAME OF CEMETERY OR CREMATORY Mt Calvary Cem.
LOCATION (City, town, or county) Brooklyn Md (State)

DATE REC'D BY LOCAL REG. 10/24/50
REGISTRAR'S SIGNATURE H.W. Hedrick DLY
24. FUNERAL DIRECTOR Elroy O. Wilson 1000 Brantly Ave ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

09895

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (In this place) O.H.
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. H. General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CROWNSVILLE
STREET ADDRESS (If rural give location) NEAR ANNAPOLIS ROAD (#178)

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
MARGARET	ANN	DUNN	OCT.	29	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
FEMALE	WHITE		Nov. 1947	2 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	—	MARYLAND	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN DUNN	Margaret Nelson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
	—	(Father) JOHN DUNN

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
3254	Immediate cause	(a) Respiratory Failure	[redacted] Sudden
84a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Mongolian Idiot Type	Since birth
		(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
John M. Clatty	M.D., Deputy Medical Examiner	Annapolis Md	10/29/50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Nov. 1-50	Balto. Cem.	Balto.	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/31/50	A. W. Hedrick	John A. Miller	2334 Jefferson Rd

51

09896

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 4 years 6 mos. 20 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
STREET ADDRESS (If rural, give location): 414 Henrietta Street

3. NAME OF DECEASED (Type or Print): (First) Elder (Middle) (Last) Durham
4. DATE OF DEATH: (Month) (Day) (Year) 10/25/50 19

5. SEX: male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: 1899
9. AGE last birthday: 51 yrs.
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Longshoreman
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Bill Durham
14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Tuberculosis of Lungs — known since 4/29/50

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia, Paranoid Type 2/1/46 — known since

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: none
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour): none m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 2/1/46, 19..., to 10/25/50, 19..., that I last saw the deceased alive on 10/25/50, 19..., and that death occurred at 8:05 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Jack Augenstein M.D.
ADDRESS: Crownsville, Md.
DATE SIGNED: 10/25/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 10/29/50
NAME OF CEMETERY OR CREMATORY: Mt Calvary Ct
LOCATION (City, town, or county) (State): A. A. Co., Md.

DATE REC'D BY LOCAL REG.: 10/27/50
REGISTRAR'S SIGNATURE: H.D. Hedrick
24. FUNERAL DIRECTOR: S.L. Brown & Son
ADDRESS: 108 W Montgomery St

90651

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09897

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Anne Arundel
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 15 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Anne Arunde
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Churchton
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Lida (Middle) Ann (Last) Franklin

4. DATE OF DEATH: (Month) Oct. (Day) 24, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Sept. 2, 1889

9. AGE last birthday: 61 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Churchton

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: ~~John W.~~ Franklin
Frank Johnson

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT: John W. Franklin

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331 X
Immediate cause (a) Cerebral Hemorrhage

260 X
61
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus, Mild

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from 10/5, 1950, to 10/25, 1950, that I last saw the deceased alive on 10/24, 1950, and that death occurred at 12:30A m., from the causes and on the date stated above.

SIGNATURE: Maurice K. Evans, Md (Degree or title) ADDRESS: Annapolis, Md DATE SIGNED: 10/25/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 10/27/50
NAME OF CEMETERY OR CREMATORY: Woodfields
LOCATION (City, town, or county) (State): Galesville, Md

DATE REC'D BY LOCAL REG.: Oct. 26, 1950
REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR: T. A. Hardesty & Son ADDRESS: Galesville, Md

VS. A15

RECEIVED
OCT 27 1950
BUREAU V. S

CAUSE OF DEATH: Dr. Claffy's statement filmed G131 2-21-51 LL

MARYLAND STATE DEPARTMENT OF HEALTH

09898

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH — COUNTY: ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ANNAPOLIS
LENGTH OF STAY in this place: about 4 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: NAVAL-ACADEMY. HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Indiana COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Terra Haute
STREET ADDRESS (If rural give location): 333-N 21st.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): HUBERT - LESTER FULTON
4. DATE OF DEATH (Month) (Day) (Year): Oct. 20 1950
5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: Jany 8, 1921
9. AGE last birthday: 29 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seaman
10b. KIND OF BUSINESS OR INDUSTRY: U.S.N.
11. BIRTHPLACE (State or foreign country): Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ROBERT FULTON
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NAVY (If yes, give war or dates of service) 6/28/50
16. SOCIAL SECURITY No.:
17. INFORMANT: U.S. NAVY.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

929.8 Immediate cause (a) Drowning — INTERVAL BETWEEN ONSET AND DEATH: Imm.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ACCIDENTAL

183 (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Severn River
(CITY OR TOWN): near Annapolis (COUNTY): A.A. (STATE): Md
TIME OF INJURY (Month) (Day) (Year) (Hour): OCT. 14, 1950 ? m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR? Unknown. Body found in Severn River. Oct. 20, 1950

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Claffy M.D. ACCIDENT (Degree or title): Deputy Medical Examiner ADDRESS: Annapolis Md. DATE SIGNED: 10/20/50

23. BURIAL, CREMATION REMOVAL (Specify): Removal
DATE THEREOF: Oct 23, 1950
NAME OF CEMETERY OR CREMATORY: To
LOCATION (City, town, or county) (State): Terre Haute, Indiana

DATE REC'D BY LOCAL REG.: Oct. 23, 1950
REGISTRAR'S SIGNATURE: [signature]
24. FUNERAL DIRECTOR: B L Hopping & Son ADDRESS: Annapolis, Md

60846

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
OCT 24 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09899

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville LENGTH OF STAY (in this place): 2 mos. 2 weeks	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 1223 N. Parrish Street

3. NAME OF DECEASED (Type or Print)	(First) Gussie	(Middle) Augusta	(Last) (Gent) Ghent	4. DATE OF DEATH	(Month) 10/31/50 (Day) (Year) 19
5. SEX: male	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: ~~not known~~ about 1885	9. AGE last birthday: 65 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): Maryland	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME: not known	14. MOTHER'S MAIDEN NAME: not known				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS: Hospital Records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
422.2 Immediate cause	(a) Chronic Myocarditis	known since 8/14/50
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senile Psychosis " "

19a. DATE OF OPERATION: none	19b. MAJOR FINDINGS OF OPERATION: none	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify): none	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE): none	
TIME OF INJURY (Month) (Day) (Year) (Hour): none m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 8/14/50, 19....., to 10/31/50, 19....., that I last saw the deceased alive on 10/31/50, 19....., and that death occurred at 8:25 P. m., from the causes and on the date stated above.

SIGNATURE: Jacob Morgenstern M.D. (Degree or title) ADDRESS: Crownsville, Md. DATE SIGNED: 11/1/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE THEREOF: 11/4/50	NAME OF CEMETERY OR CREMATORY: Mt. Auburn	LOCATION (City, town, or county) (State): Baltimore, Md.
DATE REC'D BY LOCAL REG.: 11/1/50	REGISTRAR'S SIGNATURE: A. W. Hedrick	24. FUNERAL DIRECTOR: George T. Kelson	ADDRESS: Baltimore, Md.

52086

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

09900

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ARNOLD; LENGTH OF STAY (In this place) Life; HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. General Hospital, Inc.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold; STREET ADDRESS (If rural, give location) (rural) near St. Margaret's.

3. NAME OF DECEASED (Type or Print): (First) ALBERT (Middle) (Last) HARROD

4. DATE OF DEATH: (Month) Oct. (Day) 7. (Year) 1950

5. SEX: Male

6. COLOR OR RACE: negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): SINGLE

8. DATE OF BIRTH: Aug. 26 1896

9. AGE last birthday: 54 yrs. If under 1 year: Months — Days — If under 24 hrs.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Building Contractor

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Harrod

14. MOTHER'S MAIDEN NAME: Martha Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Lillian Miller (neice)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause	(a) Acute Dilatation of Heart	sudden
932 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio-Vascular Disease	unknown
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.: INJURY OCCURRED While at work ☐ Not while at work ☐; HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE: John M. Caffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS: Annapolis Md. DATE SIGNED: 10/7/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: 10/11/1950; NAME OF CEMETERY OR CREMATORY: Mt Calvary Cemetery; LOCATION (City, town, or county) (State): Arnold- Near Annapolis, Md.

DATE REC'D BY LOCAL REG.: Oct. 10, 1950; REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR ADDRESS: Mrs. Charles E. Hicks & Son-45 Northwest

30814

RECEIVED
OCT 11 1950
BUREAU T. S

MARYLAND STATE DEPARTMENT OF HEALTH

09901

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 25

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville; LENGTH OF STAY (in this place): 2 years 6mos; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: City; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore; STREET ADDRESS (If rural, give location): 1024 Monroe Street

3. NAME OF DECEASED (Type or Print): (First) William (Middle) (Last) Hill

4. DATE OF DEATH: (Month) (Day) (Year) 10/20/50 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): sep.

8. DATE OF BIRTH: about 1877 ~~not known~~

9. AGE last birthday: 73 yrs. If under 1 year: Months; If under 24 hrs.: Days, Hours, Mln.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Hill

14. MOTHER'S MAIDEN NAME: Alemia Dyson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ~~(If yes, give war or dates of service)~~

16. SOCIAL SECURITY NO.: ~~XXX~~

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Myocarditis — known since 5/29/48

4122.2 93d

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Psychosis with Cerebral Arteriosclerosis

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) none (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 5/29/48, 19..., to 10/20/50, 19..., that I last saw the deceased alive on 10/20/50, 19..., and that death occurred at 9:34 A.m., from the causes and on the date stated above.

SIGNATURE: Jacob Thompson M.D. (Degree or title) ADDRESS: Crownsville, Maryland DATE SIGNED: 10/20/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: Oct. 30, 1950

NAME OF CEMETERY OR CREMATORY: Crownsville

LOCATION (City, town, or county) (State): Crownsville, Md.

DATE REC'D BY LOCAL REG.: Oct 2, 1950

REGISTRAR'S SIGNATURE: R. N. Joyce

24. FUNERAL DIRECTOR ADDRESS

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NOV 1 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

09902

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place) a few minutes
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural, give location) Old Annapolis Neck Road.

3. NAME OF DECEASED (Type or Print): (First) CHARLES (Middle) HENRY (Last) HOPKINS

4. DATE OF DEATH: (Month) OCT. (Day) 31 (Year) 1950

5. SEX male | 6. COLOR OR RACE white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Aug. 22. 1898 | 9. AGE last birthday 52 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Master Plumber
10b. KIND OF BUSINESS OR INDUSTRY plumbing
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edgar E. Hopkins
14. MOTHER'S MAIDEN NAME Mary Jane Hyde

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service) Yes No War I
16. SOCIAL SECURITY NO. 219-05-0255
17. INFORMANT Mrs. Charles H. Hopkins

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Acute Dilatation of Heart	Sudden
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Cardio-renal-vascular Disease	5 years
442X 12(a)	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
John M. Cheffy M.D., Deputy Medical Examiner Annapolis, Md. 11/1/50

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) | DATE THEREOF 11-3-1950 | NAME OF CEMETERY OR CREMATORY Cedar Bluff | LOCATION (City, town, or county) (State) Annapolis, Md.

DATE REC'D BY LOCAL REG. Nov. 2, 1950 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS John M. Taylor & Son Annapolis, Md.

34809

VS. A15A

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NOV 6 1950
BUREAU V. S

Evidence on Film G128
cause of death. 10/26/50s

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09903

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Annapolis Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural - Taneytown
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) ELEANOR (Middle) (Last) Kephart

4. DATE OF DEATH: (Month) October (Day) 13, (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: July 2, 1918

9. AGE last birthday: 32 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Public School

11. BIRTHPLACE (State or foreign country): Carroll County, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles B. Kephart

14. MOTHER'S MAIDEN NAME: Celia M. Yocent

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Charles B. Kephart, Taneytown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Adrenal Insufficiency	18 hr.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Septicemia	18 hr.
	(c) Autopsy revealed - typical Waterhouse-Friderichsen Syndrome. (10-26-50 - ams)	

057.1
6

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/10/, 1950, to 10/13/, 1950, that I last saw the deceased alive on 10/13/, 1950, and that death occurred at 5:45A m., from the causes and on the date stated above.

SIGNATURE: Frank M. Shipley (Degree or title): M.D. ADDRESS: 63 College Ave. Annapolis DATE SIGNED: 10/13/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 10/15/50

NAME OF CEMETERY OR CREMATORY: Lutheran Cemetery

LOCATION (City, town, or county) (State): Taneytown, Maryland

DATE REC'D BY LOCAL REG.: 10/18/50

REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR ADDRESS: C. O. Fuss & Son Taneytown, Md.

V3491

RECEIVED
OCT 20 1950
BUREAU V. S

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BIRTH NO.

1. NAME OF DECEASED (Type or Print): Maude Levroney

2. DATE OF DEATH: Oct. 19-50

3. PLACE OF DEATH: A. Baltimore City, Maryland — Morris Hill

4. USUAL RESIDENCE (Where deceased lived. If institution's residence before admission): A. STATE: Md — B. COUNTY: A. A. Co

B. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Oak St

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Morris Hill

D. STREET ADDRESS (If rural, give location): Oak Street

C. Length of stay in Baltimore: 33 yrs (Yrs. Mos. Days)

5. SEX: F

6. COLOR OR RACE: Col.

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: May 5, 1886

9. AGE (In years last birthday): 64 — If Under 1 Year: Months, Days — If Under 24 Hours: Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Prince George Co. Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Maggie Willis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Frank Levroney — ADDRESS: Morris Hill

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

I

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

(A) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days.

DUE TO

ANTECEDENT CAUSES

(B) Hypertensive Cardio renal vascular Disease ?

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

442 X

131a

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

cerebral Hemorrhage, left hemiplegia — 4 1/2 yrs.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT, SUICIDE, HOMICIDE (Specify):

21B. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.):

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21E. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10.14., 1945 *to* 10.19., 1950 *that I last saw the deceased alive on* 10.18., 1950 *and that death occurred at* 9 a. m., *from the causes and on the date stated above.*

23A. SIGNATURE: James M. Pair M. D.

23B. ADDRESS: 400 N. Carrollton Ave

23C. DATE SIGNED: 10.22.1950

24A. BURIAL, CREMATION, REMOVAL (Specify): Burial

24B. DATE: 10/22/50

24C. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem

24D. LOCATION (City, town, or county) (State): Brooklyn Md

DATE RECEIVED BY LOCAL REGISTRAR: OCT 22 1950

REGISTRAR'S SIGNATURE: Ida M. Whitson per R.F.

FUNERAL DIRECTOR: Elroy O. Wilson — ADDRESS: 1000 Brantly Ave

VS 150

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1

09905

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. .....

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Park
LENGTH OF STAY (in this place) 37 Y.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 915 Church St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Same.
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) John (Middle) P. (Last) Malinski Sr.
4. DATE OF DEATH (Month) October (Day) 8 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify) married
8. DATE OF BIRTH 1/19/86
9. AGE last birthday 64 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad car builder.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Austria, Europe.
12. CITIZEN OF WHAT COUNTRY? Austria

13. FATHER'S NAME Unknown.
14. MOTHER'S MAIDEN NAME Unknown.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.
16. SOCIAL SECURITY NO. 213-16-7584
17. INFORMANT Mrs. Stella Malinski (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Occlusion. Sudden.

420.1

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

94a

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Gustav H Pauberkus. (Degree or title) assistant medical examiner ADDRESS Glen Burnie, Md. DATE SIGNED 10/9/50.

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Oct. 12-1950
NAME OF CEMETERY OR CREMATORY Holy Cross
LOCATION (City, town, or county) A.A. Co. (State) Md

DATE REC'D BY LOCAL REG. 10/10/50
REGISTRAR'S SIGNATURE A W Hedrich
24. FUNERAL DIRECTOR Wm. S. Fialkowski ADDRESS 2007 Eastern Ave

DM

49640

MARYLAND STATE DEPARTMENT OF HEALTH

09906

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 2-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (In this place) D.A.; HOSPITAL OR INSTITUTION OR STREET ADDRESS 17 North west

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A.A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural give location) 131 Charles

3. NAME OF DECEASED (Type or Print): (First) WALTER; (Middle) CHRISTIAN; (Last) MARTIN

4. DATE OF DEATH: (Month) Oct. (Day) 30 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 6-26-1883

9. AGE last birthday: 67 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): RET- Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Commissary

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Arthur Martin

14. MOTHER'S MAIDEN NAME: MARY E MALLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Harry King (Sister)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute Dilatation of Heart	Sudden
422.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d	(b) Cardio-Vascular Disease	unknown
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY Ooccur?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Taylor (Degree or title) M.D., Deputy Medical Examiner ADDRESS Annapolis Md. DATE SIGNED 10/30/50

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) DATE THEREOF 11-2-50 NAME OF CEMETERY OR CREMATORY St. Anne's LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Nov. 2, 1950 REGISTRAR'S SIGNATURE J. T. Branch

24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md. 2669

VS-A15A

RECEIVED
NOV 6 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09907

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH · COUNTY: A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Garland Pk
LENGTH OF STAY (in this place): 26 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 326 Broadview Blvd.

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glenburnie Md (P.O.)
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print) (First) Sophia (Middle) Grace (Last) McClain
4. DATE OF DEATH (Month) Oct. (Day) 17 (Year) 1950
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow X
8. DATE OF BIRTH: April 15 1885.
9. AGE last birthday: 65 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hw.
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Baltimore Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Samuel Winters Kohler X Unknown
14. MOTHER'S MAIDEN NAME: Anne Eve Bowman Kohler
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: none.
17. INFORMANT: 418 S. McCRAIN HWY SAMUEL M. McCLAIN GLENBURNIE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Cardio-Vascular Disease	1 day
260X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Arterio Sclerosis	5 yrs.
61	(c) Diabetes M.	6 yrs.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb., 1938, to Oct. 17, 1950, that I last saw the deceased alive on Oct. 17, 1950, and that death occurred at 12:15 P.m., from the causes and on the date stated above.

SIGNATURE: Chas. L. Ball Jr. (Degree or title) ADDRESS: Linthicum DATE SIGNED: 10/17/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF: 10/20/50
NAME OF CEMETERY OR CREMATORY: Moreland Mem.
LOCATION (City, town, or county) (State): Balto Md

DATE REC'D BY LOCAL REG.: 10/18/50
REGISTRAR'S SIGNATURE: A. W. Heduck
24. FUNERAL DIRECTOR: Clarence F. Hoffmann ADDRESS: 1639 Broadway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09908

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS; LENGTH OF STAY (In this place) 1 month
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. NAVAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND; COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN RURAL ELVATON, MILLERSVILLE P.O.
STREET ADDRESS (If rural, give location) - - - - -

3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	George	Patrick	McINTOSH		10	20	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
MALE	WHITE	Married	17 March 1912	38 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
U.S. Navy	U.S. Navy	NEW YORK	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James R. McINTOSH (Deceased)	Kitty ERGLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war, or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
Yes	WW II	- - - -	Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) EMBOLISM, PULMONARY ARTERY #465	30 minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) ULCER, DUODENUM, PERFORATED #541.1	5 weeks
541.1 117b	(c) SPLEEN, INFARCTION OF #298.1	3 weeks
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	ABSCESS, PERITONEAL #576	3 weeks

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 9-20, 19 50, to 10-20, 19 50 that I last saw the deceased alive on 10-20, 19 50, and that death occurred at 2:16 A.m., from the causes and on the date stated above.

SIGNATURE: F.P. Ballenger
(Degree or title)

F.P. BALLENGER, COMMANDER, MC, USN — ADDRESS: U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. — DATE SIGNED: 10-20-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-23-50	Holy Cross Cemetery	Ritchie Hy A1A. Co. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Oct. 22, 1950		B.L. Hopping and Son	Annapolis, Md.

60896

RECEIVED
OCT 21 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09909

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severna Park; LENGTH OF STAY (in this place) 6 months; HOSPITAL OR INSTITUTION OR STREET ADDRESS Cedar Crest Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore; STREET ADDRESS (If rural, give location) 5101 W. Cold Spring Lane

3. NAME OF DECEASED (Type or Print): (First) Mathilda (Middle) A. (Last) Moore

4. DATE OF DEATH: (Month) Oct. (Day) 28 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Nov. 26, 1869

9. AGE last birthday: 80 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Wisconsin

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ?

14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY No.:

17. INFORMANT AND ADDRESS: Cedar Crest N. Home Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General Arteriosclerosis — Interval Between Onset and Death: ?

Antecedent cause(s) (b) Senility — ?

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

4500 97

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY; (CITY OR TOWN); (COUNTY); (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/8/50, 19..., to 10/28/50 19..., that I last saw the deceased alive on 10/27/50, 19..., and that death occurred at 9.45 P.M., from the causes and on the date stated above.

SIGNATURE: Gustave A. Faucherd (Degree or title) MD ADDRESS: Glen Burnie, Md. DATE SIGNED: 10/28/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial; DATE: 10/31/50; NAME OF CEMETERY OR CREMATORY: St. Peters; LOCATION (City, town, or county) (State): Baltimore, Maryland

DATE REC'D BY LOCAL REG. 10/31/50; REGISTRAR'S SIGNATURE: a. W. Hudson

24. FUNERAL DIRECTOR: Wm. Cook, Inc. ADDRESS: 1217 St. Paul Street

JT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09910

CERTIFICATE OF DEATH

Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Pk. Rl. Balto.; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 4705 Ritchie Hwy.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn Pk. Rural Balto.; STREET ADDRESS (If rural, give location) 4705 Ritchie Hwy.

3. NAME OF DECEASED (Type or Print): (First) ANNA (Middle) (Last) NAGLER

4. DATE OF DEATH: (Month) Oct. (Day) 3, (Year) 1950

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug. 23, 1882

9. AGE last birthday: 68 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Kaplan

14. MOTHER'S MAIDEN NAME: Anna ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT: 2 C Marie Drive, 20 Mr. Wm. Nagler

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) Chronic Myocarditis — Interval Between Onset and Death: 3 months

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary Occlusion — 3 months

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 6, 1950, to October 3 1950., that I last saw the deceased alive on Oct. 3, 1950., and that death occurred at 11 15 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

P. J. Ormaldi M.D. 4609 Gn. Ritchie Hway Oct 3 1950.

23. BURIAL, CREMATION, REMOVAL (Specify): burial | DATE: 10/6/50 | NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery | LOCATION (City, town, or county) (State): Baltimore, Md.

DATE REC'D BY LOCAL REG. 10/4/50 | REGISTRAR'S SIGNATURE C W Fedrick LC L | 24. FUNERAL DIRECTOR: HENRY SANDER & SONS INC. BALTIMORE - 13, MD. | ADDRESS Sig J. Sander

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09911

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH- COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN North Beach
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN same
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Baby (Middle) (Last) Powell

4. DATE OF DEATH (Month) Oct (Day) 7 (Year) 1950

5. SEX M

6. COLOR OR RACE Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH Oct. 7. 1950

9. AGE last birthday yrs. If under 1 year Months. Days If under 24 hrs. Hours 0 Min. 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) USA (Md)

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Powell

14. MOTHER'S MAIDEN NAME Alice Jenkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.

17. INFORMANT AND ADDRESS Father - North Beach, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) ? ?

020.2

Antecedent cause(s)

30f

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Probably syphilis

(c) very large liver

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. mother undertreatment for lues

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/7, 1950, to 10/7, 1950 that I last saw the deceased alive on 10/7, 1950 and that death occurred at 9 A.m., from the causes and on the date stated above.

SIGNATURE Barbara Hunt (Degree or title) M.D. ADDRESS Deale, Md. DATE SIGNED 10/7/1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 10/8/50 NAME OF CEMETERY OR CREMATORY Jessie Chapel LOCATION (City, town, or county) (State) McKendree, Md

DATE REC'D BY LOCAL REG. 10/7/50 REGISTRAR'S SIGNATURE W. R. Clayton 24. FUNERAL DIRECTOR George Powell ADDRESS Friendship, Md

1-0-0-17-0-34-3-40-V

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 11 1950
BUREAU V. S

09912

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A. A. Co Gen.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) La Rosa Hotel Main St.

3. NAME OF DECEASED (Type or Print) (First) Ezekiel (Middle) (Last) Pietrangelo
4. DATE OF DEATH (Month) Oct. (Day) 31 (Year) 1950

5. SEX M.
6. COLOR OR RACE W.
7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH ~~Unknown~~ about 1882
9. AGE last birthday About 68 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor
10b. KIND OF BUSINESS OR INDUSTRY men clothing
11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Record at Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) chronic myocarditis	3 yrs (?)
422.1 Antecedent cause(s)	(b) arteriosclerotic cardiovascular disease	10 yrs (?)
93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) i decompensation	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar., 1950, to Oct. 31, 1950, that I last saw the deceased alive on Oct 31, 1950, and that death occurred at 10 50 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) S Boorsuch M.D. ADDRESS Annapolis Md DATE SIGNED 10/31/50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE 11-4-50 NAME OF CEMETERY OR CREMATORY Cedar Bluff LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Nov. 2, 1950 REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor Sr. ADDRESS Annapolis Md.

36006

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
NOV 6 1950
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

09913

Reg. Dist. No. 22

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural, near Laurel
LENGTH OF STAY (in this place): 11 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: District Training School,

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland D.C. — COUNTY: Anne Arun
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural, near Laurel
STREET ADDRESS (If rural, give location): Laurel, Md. ✓

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) Sylvester (Last) Reid

4. DATE OF DEATH: (Month) 10- (Day) 16- (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 10-21-35

9. AGE last birthday: 14 yrs. — If under 1 year: Months | Days — If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: None.

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Joseph Anthony Reid

14. MOTHER'S MAIDEN NAME: Grace Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service): ---

16. SOCIAL SECURITY No.: None

17. INFORMANT AND ADDRESS: Welfare Bd - Dist. Trng School Laurel, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Pneumonia, Broncho-Bilateral	4 days
Antecedent cause(s)	(b) Epilepsy	Life
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Mental Retardation	Life.

3533.3
107

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: ----- 0

19b. MAJOR FINDINGS OF OPERATION: ------ 0

20. AUTOPSY? Yes XX No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): —

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: —

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 8-1-49, 19....., to 10-16-50, 19....., that I last saw the deceased alive on 10-16-50, 19....., and that death occurred at 8:30 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Benjamin E. Hodge M.D. — ADDRESS: District Trng School Laurel, Md — DATE SIGNED: 10-17-50

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE: 10-17-50 — NAME OF CEMETERY OR CREMATORY: Wash. — LOCATION (City, town, or county) (State): DC

DATE REC'D BY LOCAL REG.: 10-17-50 — REGISTRAR'S SIGNATURE: Clara Hasluf

24. FUNERAL DIRECTOR: James T Ryan — ADDRESS: Wash DC

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09914

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A.A. Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ARNOLD, MD.
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD. COUNTY A.A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ARNOLD, MD.
STREET ADDRESS (If rural, give location) ARNOLD, MD.

3. NAME OF DECEASED (Type or Print) (First) MATHILDA (Middle) (Last) ROCHLITZ

4. DATE OF DEATH (Month) 10 (Day) 30 (Year) 1950

5. SEX F

6. COLOR OR RACE W

7. ~~SINGLE~~, ~~MARRIED~~, WIDOWED, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH 5/8/1866

9. AGE last birthday 84 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY NONE

11. BIRTHPLACE (State or foreign country) GERMANY

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME CARL THEUNE

14. MOTHER'S MAIDEN NAME UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. —

17. INFORMANT AND ADDRESS CHRISTIAN ROCHLITZ, ARNOLD, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cardio-Vascular Renal Disease	
442X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) c̄ Decompensation	4 mos.
131a	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from February, 1950, to 10/30, 1950, that I last saw the deceased alive on 10/30, 1950, and that death occurred at 9 30 p. m., from the causes and on the date stated above.

SIGNATURE Maurice Klawans, MD (Degree or title) ADDRESS Annapolis Md DATE SIGNED 11/1/50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify) DATE THEREOF 11/2/50 NAME OF CEMETERY OR CREMATORY ASBURY CEMETERY LOCATION (City, town, or county) ARNOLD, (State) MD.

DATE REC'D BY LOCAL REG. Nov. 2, 1950 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR JOHN M. TAYLOR & SON ADDRESS ANNAPOLIS, MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

09915

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville; LENGTH OF STAY (in this place) 2 years, 42 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Balto City; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore; STREET ADDRESS (If rural, give location) 760 Waesche Street

3. NAME OF DECEASED (Type or Print): (First) Ollie; (Middle); (Last) Sanders

4. DATE OF DEATH: (Month) 10; (Day) 12; (Year) 1950

5. SEX: Female

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: about 1879

9. AGE last birthday: 71 yrs.; If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Walter Briscoe

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: not known

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Tuberculosis of lungs	6/23/50
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) General Paresis	8/31/48

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: none

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): none m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 8/31, 1950, to 10/12, 1950, that I last saw the deceased alive on 10/12, 1950, and that death occurred at 3 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): [signature] M.D.

ADDRESS: Crownsville, Md.

DATE SIGNED: 10/12/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 10/14/50

NAME OF CEMETERY OR CREMATORY: Mt. Auburn

LOCATION (City, town, or county) (State):

DATE REC'D BY LOCAL REG. October 14 1950

REGISTRAR'S SIGNATURE: RW

24. FUNERAL DIRECTOR: A. Halstead - 918 -

ADDRESS: Linn Hill ave.

52086

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09916

CERTIFICATE OF DEATH

Reg. Dist. No. 2-3

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN High Point (Pasadena P.O.); LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Pine Knobb Road - Box 299 - RFD 3

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN High Point (Pasadena P.O.); STREET ADDRESS (If rural give location) Pine Knobb Road - Box 299, Route - 3

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
Richard	Lee	Sanner	October 22, 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	White	Married	September 23, 1890	60 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cabinet Maker (Retired)	Custom-made Work	St. Mary's Co. Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Richard Sanner	Nancy Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
	220-14-9027	Mrs. Charles Schaeffer - Daughter

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinomatosis	7 months
157X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 46g	(b) Carcinoma of pancreas	not known
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Sept 1, 1950, to Oct. 22, 1950, that I last saw the deceased alive on Oct 8, 1950, and that death occurred at 4:45 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Randall M. McLaughlin, M.D		Pasadena P.O., Md.	October 22, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-25-50	Glen Haven	Glen Burnie, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/24/50	L. J. Dallas	Richard V. Singleton	

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MARYLAND STATE DEPARTMENT OF HEALTH

09917

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place) D.O.A.
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold (Belvedere Beach)
STREET ADDRESS (If rural give location) Riverside Beach

3. NAME OF DECEASED (Type or Print): (First) ROBERT (Middle) (Last) SHERMAN

4. DATE OF DEATH: (Month) OCT (Day) 20 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: July 1, 1949

9. AGE last birthday: 1 yrs. If under 1 year: Months 3 Days 19 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Sherman

14. MOTHER'S MAIDEN NAME: Ellie Bayce

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Charles Sherman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

929.0 **Immediate cause** (a) Drowning — sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

183 (b) Accidental

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home

(CITY OR TOWN) Arnold (COUNTY) A.A. (STATE) Md

TIME OF INJURY (Month) Oct. (Day) 20. (Year) 1950 (Hour) 6:50 p.m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR? Fell into 5 gal. crock ~~and~~ head first

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Caffey, M.D., Deputy Medical Examiner, Annapolis, Md. 10/20/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Oct 22, 50

NAME OF CEMETERY OR CREMATORY Asbury Methodist

LOCATION (City, town, or county) (State) Arnold, Md.

DATE REC'D BY LOCAL REG. Oct. 22, 1950

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS

B. F. Hopping & Son, Annapolis, Md

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OCT 24 1950
BUREAU Y. &

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09918

CERTIFICATE OF DEATH

Reg. Dist. No. 20

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Aa — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lothian
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Life

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Aa
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lothian
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Joan (Middle) Julia Ann (Last) Herbert

4. DATE OF DEATH: (Month) 10 (Day) 2 (Year) 1950

5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Wid | 8. DATE OF BIRTH March 3, 1865 | 9. AGE last birthday 85 yrs. | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Md | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Richard Crosby | 14. MOTHER'S MAIDEN NAME Sarah Moreland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If year, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT AND ADDRESS Mrs. Pearl Crandell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

151X **Immediate cause** (a) Carcinoma of Stomach — 6 mo

Antecedent cause(s)

46b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1950, to Oct 2, 1950, that I last saw the deceased alive on Oct 2, 1950, and that death occurred at 7.00 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Hugh W Ward Owings Md 10/3/50

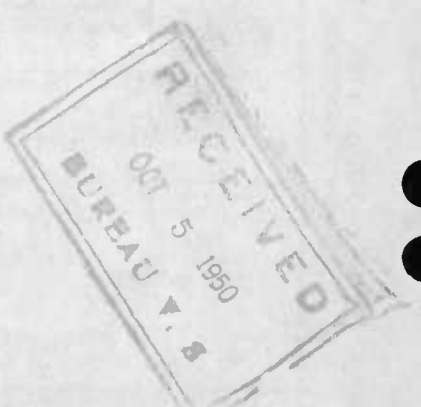
23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE Oct. 5 1950 | NAME OF CEMETERY OR CREMATORY Mt. Zion | LOCATION (City, town, or county) (State) Lothian, Md.

DATE REC'D BY LOCAL REG. 10/3/50 | REGISTRAR'S SIGNATURE D.M. Clayton

24. FUNERAL DIRECTOR ADDRESS T.A. Hardesty & Son Galesville, Md

52086

John W. Shubert



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09919

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY: A. A. Co. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Md. COUNTY: A. A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Jessups — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Jessup
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location): Box 26

3. NAME OF DECEASED (Type or Print) (First) CHARLES (Middle) (Last) SIEGWART		4. DATE OF DEATH (Month) October (Day) 11th (Year) 1950	
5. SEX: M.	6. COLOR OR RACE: W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Aug. 26, 1863
9. AGE last birthday: 87 yrs.	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Forest	10b. KIND OF BUSINESS OR INDUSTRY: own business	11. BIRTHPLACE (State or foreign country): Ems, Switzerland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Anton Siegwart		14. MOTHER'S MAIDEN NAME: Christencia Zerkie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service)	16. SOCIAL SECURITY No.: none	17. INFORMANT: Mrs. C. A. Siegwart, Jessup, Md.	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial Insuff. — 6 wks.

422.1 Antecedent cause(s) (b) arterio-sclerosis — 4 yrs.

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1st, 1950, to Oct. 11, 1950, that I last saw the deceased alive on Oct. 11th, 1950, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Frank Shipley	M.D.	Savage, Md.	10/12/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial	DATE: Oct. 14, 50	NAME OF CEMETERY OR CREMATORY: Meadow Ridge Mem.	LOCATION (City, town, or county): Dorsey Md. (State)
DATE REC'D BY LOCAL REG.: 10-13-50	REGISTRAR'S SIGNATURE: A. W. Hedrick	24. FUNERAL DIRECTOR: HENRY SANDER & SONS, INC. BALTIMORE - 13, MD.	ADDRESS: Geo. F. Sander

15675

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09920

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A A Annapolis MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (in this place) 50 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE 90 Calvert St. COUNTY AA
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print) (First) Albert (Middle) Clifford (Last) Stanton

4. DATE OF DEATH (Month) 10 (Day) 6 (Year) 1950

5. SEX M

6. COLOR OR RACE Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH 7-4-1900

9. AGE last birthday 50 yrs. If under 1 year Months 3 Days 2 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fright Checker

10b. KIND OF BUSINESS OR INDUSTRY Railroad

11. BIRTHPLACE (State or foreign country) Arnold, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Lewis Stanton

14. MOTHER'S MAIDEN NAME Mary Sowney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY No. 217-03-9751

17. INFORMANT 90 Calvert St. Estella Stanton Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
444X	Immediate cause (a)	Acute Myocarditis	5 hrs
93d	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)	Arterial Hypertension	5 hrs
	(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 10, 1950, to Oct 6, 1950, that I last saw the deceased alive on Oct 6, 1950, and that death occurred at 11:45 A.M., from the causes and on the date stated above.

SIGNATURE Robt. Rubin on Dr. (Degree or title) MD ADDRESS 110 - Clay St Annapolis, Md. DATE SIGNED 10/9/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF 10-9-50

NAME OF CEMETERY OR CREMATORY Mt. Calvery

LOCATION (City, town, or county) (State) Arnold, Md.

DATE REC'D BY LOCAL REG. Oct. 9, 1950

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR William Reese ADDRESS 108 Washington St. Annapolis, Md.

26647

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OCT 10 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

09921

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sylvan Shores
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Riva Md.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Riva Md.
STREET ADDRESS (If rural, give location) Sylvan Shores.

3. NAME OF DECEASED (Type or Print): (First) Cordelia (Middle) (Last) Stewart

4. DATE OF DEATH: (Month) 10 (Day) 12 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED;~~ (Specify)

8. DATE OF BIRTH: 7-3-1873

9. AGE last birthday: 78 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY —

11. BIRTHPLACE (State or foreign country): Indiana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alan L. Prather

14. MOTHER'S MAIDEN NAME: Hannah Linton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT AND ADDRESS: John Stewart Riva Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardio Vascular Failure — Interval between onset and death: sudden

434.3 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Acute Dilatation of Heart — about 1 wk.

950 (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Oct 11th, 1950, to Oct 17, 1950, that I last saw the deceased alive on Oct 17, 1950, and that death occurred at 3:25 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) J. Oliver Purvis — ADDRESS Annapolis Md — DATE SIGNED 10/12/50

23. ~~BURIAL, CREMATION~~ REMOVAL (Specify) — DATE THEREOF Oct 12-1950 — NAME OF CEMETERY OR CREMATORY Hyattsville Md. — LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. Oct. 12, 1950 — REGISTRAR'S SIGNATURE [illegible] — 24. FUNERAL DIRECTOR Wm Gasch & Sons — ADDRESS Hyattsville Md

RECEIVED
OCT 16 1950
BUREAU U. S.

Evidence for addition of #18 &21 shown on:

FILM No. G 1 2 NOV 3 -1950

09922

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY Anne Arundel Co. MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Delaware COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Harundale — LENGTH OF STAY (in this place) 1 year	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wilmington
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1314 Howard Road	STREET ADDRESS (If rural, give location) 419 S. Bancroft Pkway

3. NAME OF DECEASED (Type or Print)	(First) John	(Middle) Thomas	(Last) Stone	4. DATE OF DEATH	(Month) 10	(Day) 24	(Year) 1950
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3-27-17	9. AGE last birthday 33 yrs.	If under 1 year Months / Days	If under 24 hrs. Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Columbia, S. C.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Ira Thomas Stone			14. MOTHER'S MAIDEN NAME Pearl Estell Davis				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ✓ (If yes, give war or dates of service) W.W.II	16. SOCIAL SECURITY No.		17. INFORMANT Mrs. Marion Stone				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

870.0 Immediate cause (a) MORPHINISM

179M Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Ingestion of paraldehyde

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. primary | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home | (CITY OR TOWN) (COUNTY) (STATE) 1314 Howard Rd., Harundale, Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) Oct. 24, 1950 7pm m. | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? Ingestion of morphine and paraldehyde (11-3-50 akc)

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
William V Lovett	M.D.	700 Fleet Street	10-25-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	10-27-50	unknown	Columbia S.C.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10/26/50	L. J. DeAlba	Thomas W. Singleton	Glen Burnie Md

V 3292

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

RECEIVED
OCT 27 1950

MARYLAND STATE DEPARTMENT OF HEALTH

09923

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place): 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eastport
STREET ADDRESS (If rural, give location): 225 Severn Avenue

3. NAME OF DECEASED (Type or Print): (First) David (Middle) Bruce (Last) Thetford

4. DATE OF DEATH: (Month) 10 (Day) 20 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: 10-20-50

9. AGE last birthday: yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours 12 / Min. 10

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): -

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Eugene Thetford

14. MOTHER'S MAIDEN NAME: Sioux Rita Bridges

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): - (If yes, give war or dates of service): -

16. SOCIAL SECURITY NO.: -

17. INFORMANT AND ADDRESS: U.S. Naval Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) #560.2 Shock, due to operative procedure for — 1hr 15min

560.2

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hernia, umbilical congenital 560.5 With

1579

(c) Eventration irreducible intestinal congenital

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 10-20-50

19b. MAJOR FINDINGS OF OPERATION: Hernia, umbilical congenital with Eventration irreducible intestinal congenital

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-20, 19 50, to 10-20, 19 50, that I last saw the deceased alive on 10-20, 19 50, and that death occurred at 1250 pm., from the causes and on the date stated above.

SIGNATURE: R.F. Cantrell (Degree or title) — ADDRESS — DATE SIGNED: 21 October 1950

R.F. Cantrell, Captain, MC, USN

23. BURIAL, ~~CREMATION~~ ~~REMOVAL (Specify)~~ — DATE THEREOF: Oct 23-1950 — NAME OF CEMETERY OR CREMATORY: U.S. NAVAL ACADEMY — LOCATION (City, town, or county) (State): Annapolis Md.

DATE REC'D BY LOCAL REG.: Oct. 23, 1950 — REGISTRAR'S SIGNATURE: [signature] — 24. FUNERAL DIRECTOR — ADDRESS: John M. Taylor Son Annapolis, Md.

2-0-C-20-0-19+1-40-2

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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OCT 24 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

09924

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place) 2 yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport; STREET ADDRESS (If rural give location) 339 Burnside Ave

3. NAME OF DECEASED (Type or Print): (First) THOMAS (Middle) JAMES (Last) THOMAS

4. DATE OF DEATH: (Month) OCT. (Day) 30, (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): WIDOWER

8. DATE OF BIRTH: NOV. 20 1881

9. AGE last birthday: 68 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WATERMAN

10b. KIND OF BUSINESS OR INDUSTRY: Fishing & Crabbing

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY No.:

17. INFORMANT: Seneva May Wentworth

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	Sudden
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a	(b) Coronary sclerosis	2 or more years
	(c)	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Caffey M.D. Deputy Medical Examiner Annapolis Md. 10/30/50

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify): DATE THEREOF 11-2-1950 NAME OF CEMETERY OR CREMATORY Edwards Chapel LOCATION (City, town or county) Anne Arundel Co. (State) Md.

DATE REC'D BY LOCAL REG. Oct 31, 1950 REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR John M. Taylor & Son ADDRESS Annapolis, Md.

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NOV 1 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09925

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Homewood Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) EMMA (Middle) VIRGINIA (Last) TUCKER

4. DATE OF DEATH (Month) Oct. (Day) 29 (Year) 1950

5. SEX Female
6. COLOR OR RACE White
7. ~~SINGLE, MARRIED,~~ WIDOWED, ~~DIVORCED,~~ (Specify)
8. DATE OF BIRTH 10-15-74
9. AGE last birthday 76 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Floyd Schekler
14. MOTHER'S MAIDEN NAME unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS John L. Tucker Riva, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Stomach — INTERVAL BETWEEN ONSET AND DEATH: Sound

15/X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) — Minutes

46b

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis — unknown

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1, 1950, to Oct 29, 1950, that I last saw the deceased alive on Oct 29, 1950, and that death occurred at 10 p m., from the causes and on the date stated above.

SIGNATURE George C Basil (Degree or title) M D ADDRESS Humphrey Md DATE SIGNED 10-30-50

23. BURIAL, ~~CREMATION REMOVAL (Specify)~~ DATE THEREOF 11-1-50 NAME OF CEMETERY OR CREMATORY Cedar Bluff LOCATION (City, town, or county) Annapolis (State) Md.

DATE REC'D BY LOCAL REG. Oct. 31, 1950 REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

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VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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NOV 1 1950
BUREAU V. S

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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MARYLAND STATE DEPARTMENT OF HEALTH

09926

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Linthicum
LENGTH OF STAY (in this place) Few minutes
HOSPITAL OR INSTITUTION OR STREET ADDRESS 108 - Maples Rd.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore - 30
STREET ADDRESS (If rural give location) 2239 - Sydney Avenue.

3. NAME OF DECEASED (Type or Print) (First) Lorenzo (Middle) Valenzia (Last).
4. DATE OF DEATH (Month) 10 (Day) 19 (Year) 1950

5. SEX M.
6. COLOR OR RACE White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify) married.
8. DATE OF BIRTH 5/13/93
9. AGE last birthday 57 yrs. If under 1 year: Months | Days. If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer.
10b. KIND OF BUSINESS OR INDUSTRY OWN FARM
11. BIRTHPLACE (State or foreign country) Italy, (Europe).
12. CITIZEN OF WHAT COUNTRY? Italy.

13. FATHER'S NAME Salvatore Valenzia
14. MOTHER'S MAIDEN NAME ? JOSEPHINE CICERIO.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Salvatore Valenzia (Son). SEVERN MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Coronary Occlusion	Sudden.
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. —
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY —
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Gustave H. Fauber MD (Degree or title) assistant medical examiner. ADDRESS - Glen Burnie, Md. DATE SIGNED 10/19/50.

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF OCT 23 50
NAME OF CEMETERY OR CREMATORY GLEN HAVEN
LOCATION (City, town, or county) GLEN BURNIE (State) MD.

DATE REC'D BY LOCAL REG. 10/20/50
REGISTRAR'S SIGNATURE [signature] DeAlba
24. FUNERAL DIRECTOR Thomas W. Singleton ADDRESS

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RECEIVED
OCT 23 1950
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09927

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY AA Annapolis, MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 69 College Ck. Terrace

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY a.a.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 69 College Ck. Trs.

3. NAME OF DECEASED (Type or Print) (First) Maurice (Middle) Gregory (Last) Wade

4. DATE OF DEATH (Month) 10 (Day) 13 (Year) 1950

5. SEX Male
6. COLOR OR RACE Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 2-3-1908
9. AGE last birthday 43 yrs. If under 1 year Months 8 Days 10 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Water & Cook Annapolis
10b. KIND OF BUSINESS OR INDUSTRY Yacth Club
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Mitchell Wade
14. MOTHER'S MAIDEN NAME Clara M. Randall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-12-3472
17. INFORMANT Vivian Wade

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

155 X Immediate cause (a) Primary Carcinoma of liver — INTERVAL BETWEEN ONSET AND DEATH 2 months

46 f Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1st, 1950, to Oct 13, 1950, that I last saw the deceased alive on Oct 13, 1950, and that death occurred at 9:30 P m., from the causes and on the date stated above.

SIGNATURE R. L. Richardson MD (Degree or title) ADDRESS 110 - Clay St Annapolis Md DATE SIGNED 10/15/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 10-16-50
NAME OF CEMETERY OR CREMATORY Brewer Hill Cemetery
LOCATION (City, town, or county) Annapolis, AA (State) Md.

DATE REC'D BY LOCAL REG. 10/16/50
REGISTRAR'S SIGNATURE A. W. Hedrick JT
24. FUNERAL DIRECTOR William Reese ADDRESS 108 Washington St. Annapolis, Md.

78090

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09928

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH
COUNTY: Anne Arundel (Brooklyn) MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore (Curtis)
LENGTH OF STAY (in this place): 72 7/12 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 6017 Ritchie Highway A.A.Co.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
STREET ADDRESS (If rural, give location): 6017 Ritchie Highway A.A.Co.

3. NAME OF DECEASED (Type or Print): (First) Henry (Middle) J. (Last) Wallace

4. DATE OF DEATH: (Month) 10/30/ (Day) (Year) 1950 19

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 10/6/1878

9. AGE last birthday: 72 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill Operator

10b. KIND OF BUSINESS OR INDUSTRY: Chrome Mill

11. BIRTHPLACE (State or foreign country): Ann Arundel Co.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Lloyd Wallace

14. MOTHER'S MAIDEN NAME: Fannie Robison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-01-3855

17. INFORMANT: Eugene L. Wallace 6017 Ritchie Hwy

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

4143x Immediate cause (a) Chronic Myocarditis — 1 yr.

93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Arterial Hypertension — 6 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1947, to October, 1950, that I last saw the deceased alive on 10-26, 1950, and that death occurred at 5.30 A.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
P. J. Ammaldi M.D. | 4609 Gor. Ritchie Hway | 10-31-50.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: 11/2/50 | NAME OF CEMETERY OR CREMATORY: Mt. Calvary | LOCATION (City, town, or county) (State): Ann Arundel Co. Md.

DATE REC'D BY LOCAL REG.: Oct-31,1950 | REGISTRAR'S SIGNATURE: a.w. Kedrick

24. FUNERAL DIRECTOR | ADDRESS
Holland Funeral Home
1631 Druid Hill Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09929

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 21 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore, Maryland
STREET ADDRESS (If rural, give location) 941 S. Baylis Street

3. NAME OF DECEASED (Type or Print): (First) Phillip (Middle) (Last) Washington

4. DATE OF DEATH: (Month) (Day) (Year) 10/9/50 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): not known

8. DATE OF BIRTH: not known 10-20-1879

9. AGE last birthday: 75 (?) yrs. If under 1 year: Months Days; If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): not known RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): not known VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: not known

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. [redacted]

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause (a)	Generalized Arteriosclerosis	known since 9/18/50
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)		
(c)		

450.0
97

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): none m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 9/18/50, 19....., to 10/9/50, 19....., that I last saw the deceased alive on 10/9/50, 19....., and that death occurred at 7:45 A.M. m., from the causes and on the date stated above.

SIGNATURE: Jacob Hrycenko M.D. (Degree or title)
ADDRESS: Crownsville, Md.
DATE SIGNED: 10/9/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 10-14-1950
NAME OF CEMETERY OR CREMATORY: Mt Calvary Cem A.A. Co
LOCATION (City, town, or county) (State): Md

DATE REC'D BY LOCAL REG.: 10/11/50
REGISTRAR'S SIGNATURE: Rob Kadrud

24. FUNERAL DIRECTOR: Raymer Sanders
ADDRESS: 1412 E. Preston St

09930

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 1½ months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural, give location) 1116 Druid Hill Avenue

3. NAME OF DECEASED (Type or Print) (First) George (Middle) (Last) Watkins

4. DATE OF DEATH (Month) 10 (Day) 13 (Year) 1950

5. SEX Male

6. COLOR OR RACE Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH 3/19/03

9. AGE last birthday 47 yrs. If under 1 year Months — Days — If under 24 hrs. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter

10b. KIND OF BUSINESS OR INDUSTRY Dep't. Store

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Unknown

14. MOTHER'S MAIDEN NAME Mary Queen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. - - - - - -

17. INFORMANT AND ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myodegeneration cardis — Known to us since adm. 8/21/50

422.2

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Organic brain disease

93d

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION - - - - - -

19b. MAJOR FINDINGS OF OPERATION -

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) - - - - - -

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) -

TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - - - - - m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? -

22. I hereby certify that I attended the deceased from 8/21, 1950, to 10/13, 1950, that I last saw the deceased alive on 10/13, 1950, and that death occurred at 7:30 A. m., from the causes and on the date stated above.

SIGNATURE Jack Morgenstern M.D. (Degree or title) ADDRESS Crownsville State Hospital DATE SIGNED 10/13/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE THEREOF Oct 17 1950 — NAME OF CEMETERY OR CREMATORY Fowler's Chapel — LOCATION (City, town, or county) Best Gate (State) Md

DATE REC'D BY LOCAL REG. Oct. 17, 1950 — REGISTRAR'S SIGNATURE R. M. Joyce — 24. FUNERAL DIRECTOR J. B. Johnson — ADDRESS Annapolis

750 63

RECEIVED
OCT 24 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09931

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis,
LENGTH OF STAY (in this place): 3Days 22 hrs,40Min.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural give location): RFD#1,Box 178

3. NAME OF DECEASED (Type or Print): (First) Baby (Middle) Boy (A) (Last) WHITE

4. DATE OF DEATH: (Month) October (Day) 12 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 8 Oct. 1950

9. AGE last birthday: yrs.
If under 1 year: Months; Days: 3
If under 24 hrs.: Hours: 22; Min.: 40

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): USNH,Annapolis,Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert Leslie White

14. MOTHER'S MAIDEN NAME: Evelyn Ruth Wyman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service): - - - -

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Hospital Records,USNH,Annapolis,Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

762.5 Immediate cause (a) PREMATURITY (6th. Month) — Interval between onset and death: 3 days, 22hrs 40 Min.

Antecedent cause(s)

159 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) ATELECTASIS — Interval between onset and death: "

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8 Oct.1950 to 12 Oct., 1950, that I last saw the deceased alive on 12 Oct., 1950, and that death occurred at 3:15 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

K.M. COVERDALE, LTJG,MC,USN., U.S. Naval Hospital,Annapolis,Maryland. 10-13-50.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 10-13-50
NAME OF CEMETERY OR CREMATORY: Naval Cemetery
LOCATION (City, town, or county) (State): Annapolis, Maryland

DATE REC'D BY LOCAL REG.: Oct. 13, 1950
REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR: B.L. Hopping and Son
ADDRESS: Annapolis, Md.

2-1-B-08-0-3-2-25-0

RECEIVED
OCT 16 1950
BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09932

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis,
LENGTH OF STAY (in this place): 1 hr. & 53 min.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: U.S. Naval Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural give location): RFD#1, Box # 178.

3. NAME OF DECEASED (Type or Print): (First) Baby Boy (Middle) (Last) WHITE

4. DATE OF DEATH: (Month) October (Day) 8 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 8 Oct. 1950

9. AGE last birthday: yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours 1 — Min. 53

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): USNH, Annapolis, Md.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Robert Leslie White

14. MOTHER'S MAIDEN NAME: Evelyn Ruth Wyman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Hospital Records, USNH Annapolis, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

762.5 Immediate cause (a) PREMATURITY (6th. Month) — Interval Between Onset and Death: 1 hr. & 53 Min.

159 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Atelectasis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8 Oct., 1950, to 8 Oct., 1950, that I last saw the deceased alive on 8 Oct., 1950, and that death occurred at 9:30 p.m., from the causes and on the date stated above.

SIGNATURE: R.K. Brooks (Degree or title) — ADDRESS: R.K. BROOKS, LCDR, MC, USN., U.S. Naval Hospital, Annapolis, Md. — DATE SIGNED: 9 October 1950

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Oct 10, 1950 — NAME OF CEMETERY OR CREMATORY: U.S. Naval Cemetery — LOCATION (City, town, or county) (State): Annapolis, Md.

DATE REC'D BY LOCAL REG.: Oct. 10, 1950 — REGISTRAR'S SIGNATURE: [signature] — 24. FUNERAL DIRECTOR — ADDRESS: B. L. Hopping & Son Annapolis, Md.

2-1-0-08-0-31 N2-25-0

RECEIVED
OCT 11 1950
BUREAU V. S

09933

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Princess Anne
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Bernie (Middle) (Last) White
4. DATE OF DEATH (Month) (Day) (Year) 10/18/50 19

5. SEX male
6. COLOR OR RACE colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH about 1880 not known
9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) not known
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Somerset
12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME Horace Wolcott not known
14. MOTHER'S MAIDEN NAME Hannetta Pollitt not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
334X	Immediate cause	(a) Cerebral Arteriosclerosis	known since 1/8/50
97	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Psychosis with Cerebral Arteriosclerosis	" "
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION none
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) none
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) none
TIME OF INJURY (Month) (Day) (Year) (Hour) none m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 1/8/50, 19....., to 10/18/50, 19....., that I last saw the deceased alive on 10/18/50, 19....., and that death occurred at 11:55 A.m., from the causes and on the date stated above.

SIGNATURE Jacob Morgenstern M.D. (Degree or title) ADDRESS Crownsville, Md. DATE SIGNED 10/18/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 10-21-50
NAME OF CEMETERY OR CREMATORY Grace
LOCATION (City, town, or county) Venton (State) Md

DATE REC'D BY LOCAL REG. 10/21/50
REGISTRAR'S SIGNATURE R. S. Thomas M.D. Caldwell Woodruff M.D.
24. FUNERAL DIRECTOR William H. Jones Jr. ADDRESS Princess Anne Md

XVX99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 25 1950
BUREAU V. S

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

09934

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville; LENGTH OF STAY (in this place) 1 year 1 mos.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Prince Geo.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brandywine; STREET ADDRESS (If rural, give location) none

3. NAME OF DECEASED (Type or Print): (First) Albert (Middle) (Last) Wilson

4. DATE OF DEATH: (Month) 10/.1/50 (Day) (Year) 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widower

8. DATE OF BIRTH: June, 1889

9. AGE last birthday: 61 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer-farm helper

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Calvert, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Jim Wilson

14. MOTHER'S MAIDEN NAME: Annie Watkins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. [redacted]

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General Paresis — Interval Between Onset and Death: known since 9/7/49

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: none (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): none m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 9/7/49, 19..., to 10/1/50, 19..., that I last saw the deceased alive on 10/1/50, 19..., and that death occurred at 4:45 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Jacob Klingenstein M.D. ADDRESS Crownsville, Md. DATE SIGNED 10/2/50

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. 10-2. | REGISTRAR'S SIGNATURE K. M. Joy | 24. FUNERAL DIRECTOR P. E. Sewell ADDRESS

RECEIVED
OCT 13 1960
BUREAU V. R.

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

09935

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Riva
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY a a.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Shadyside
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) FRITZ (Middle) (Last) Witt

4. DATE OF DEATH (Month) Oct (Day) 18 (Year) 1950

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed

8. DATE OF BIRTH 11-8-~~89~~65

9. AGE last birthday 84 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman

10b. KIND OF BUSINESS OR INDUSTRY Oystering

11. BIRTHPLACE (State or foreign country) Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ?

14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) no

16. SOCIAL SECURITY No. none

17. INFORMANT AND ADDRESS Bernard Hardesty

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
	Immediate cause	(a) Coronary Thrombosis	6 days
420.1	Antecedent cause(s)		
93d	Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertensive Cardio-Vascular Disease	10 yrs.
		(c) Senility	10 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-13-, 1950, to 10-19, 1950, that I last saw the deceased alive on 10-18, 1950, and that death occurred at 2 45 P.m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) M.D. ADDRESS Annapolis, Md. DATE SIGNED 10-19-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE 10-20-50

NAME OF CEMETERY OR CREMATORY Quaker

LOCATION (City, town, or county) Galesville (State) Md.

DATE REC'D BY LOCAL REG. Oct. 19, 1950

REGISTRAR'S SIGNATURE [signature]

24. FUNERAL DIRECTOR T A Hardesty & Son ADDRESS

900 V1

RECEIVED
OCT 26 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

09936

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH · COUNTY ~~Balto.~~ ANNE ARUNDEL MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE MD. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Green Haven — LENGTH OF STAY (in this place) 20 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Green Haven Pasedena P.O
HOSPITAL OR INSTITUTION OR STREET ADDRESS Green Have	STREET ADDRESS (If rural give location) Green Haven

3. NAME OF DECEASED (Type or Print)	(First) Henry	(Middle)	(Last) Wolf	4. DATE OF DEATH	(Month) 10-26-50 (Day) (Year) 19
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 2-22-73	9. AGE last birthday 77 yrs.	If under 1 year Months Deys; If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Laborer	11. BIRTHPLACE (State or foreign country) Baltimore	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT George M. Taylor			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary thrombosis	1 hour
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) hypertension	3 months
94a	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. rheumatoid arthritis — 3 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 21, 1950, to Oct. 26, 1950, that I last saw the deceased alive on Oct. 19, 1950, and that death occurred at 10:20 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
R. M. McLaughlin	M.D.	Pasadena P.O, Md.	Oct. 26. 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 10-30-50	NAME OF CEMETERY OR CREMATORY Mt. Carmel	LOCATION (City, town, or county) (State) Baltimore Md.
DATE REC'D BY LOCAL REG. 10/30/50	REGISTRAR'S SIGNATURE A. W. Hearing JT	24. FUNERAL DIRECTOR Kelly & John Chen	ADDRESS 403 S. Wolfe Street 98899

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

09937

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ferndale. LENGTH OF STAY (in this place) 7 years.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 108 - First ave. -

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland. COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 210 - Penn St.

3. NAME OF DECEASED (Type or Print) (First) Pius (Middle) Joseph (Last) ZELNER.
4. DATE OF DEATH (Month) Oct. (Day) 16 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH 5/4/92
9. AGE last birthday 58 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Emp. Tailor
10b. KIND OF BUSINESS OR INDUSTRY Calvert Clothes
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Pius J. Zelner.
14. MOTHER'S MAIDEN NAME Margaret Kartovich.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 212-01-0265
17. INFORMANT AND ADDRESS Mrs. Tessie E. Zelner (wife.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
420.1	Immediate cause	(a) Coronary Thrombosis -	2 1/2 hrs.
94a	Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Disseminated Arthritis	16 years.
		(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from June, 1945, to October, 1950, that I last saw the deceased alive on 10/16/50, 19....., and that death occurred at 9.30 P.m., from the causes and on the date stated above.

SIGNATURE Gustave H. Pauber Md. (Degree or title) ADDRESS Glen Burnie, Md. DATE SIGNED 10/16/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 10/21/50
NAME OF CEMETERY OR CREMATORY Holy Cross
LOCATION (City, town, or county) Ritchie Hgw. (State) Md.

DATE REC'D BY LOCAL REG. 10-18-50
REGISTRAR'S SIGNATURE L
24. FUNERAL DIRECTOR Charles W. Kachauskas 703 McHenry St. ADDRESS Balto 30 Md.

496.06

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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